



NAU COUNTRY INSURANCE CO.
7333 SUNWOOD DRIVE NW
RAMSEY, MN 55303-4700

CHECK ONE:

- HOME OFFICE-RAMSEY, MN
- BRANCH OFFICE-FARGO, ND
- BRANCH OFFICE-WOODLAND, CA
- BRANCH OFFICE -EAU CLAIRE, WI
- BRANCH OFFICE -TOPEKA, KS
- BRANCH OFFICE-MISSOULA, MT
- REGIONAL OFFICE-FRESNO, CA
- OTHER

INSURED'S NAME: INSURED'S AUTHORIZED REPRESENTATIVE: INSURED'S ADDRESS: CITY STATE ZIP The undersigned does hereby make, constitute and appoint NAME OF APPOINTEE: APPOINTEE'S ADDRESS: CITY STATE ZIP In the County of and State of:	AGENCY CODE: AGENCY NAME & ADDRESS: CROPS:	POLICY NUMBER: REMARKS:
NONDISCRIMINATION STATEMENT		
<p>The U.S. Department of Agriculture (USDA) prohibits discrimination in all its programs and activities on the basis of race, color, national origin, age, disability, and where applicable, sex, marital status, familial status, parental status, religion, sexual orientation, genetic information, political beliefs, reprisal, or because all or a part of an individual's income is derived from any public assistance program. (Not all prohibited bases apply to all programs.) Persons with disabilities who require alternative means for communication of program information (Braille, large print, audiotape, etc.) should contact USDA's TARGET Center at (202) 720-2600 (voice and TDD). To file a complaint of discrimination, write to: USDA, Director, Office of Civil Rights, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, or call (800) 795-3272 (voice) or (202) 720-6382 (TDD). USDA is an equal opportunity provider and employer.</p>		
COLLECTION OF INFORMATION AND DATA (PRIVACY ACT) STATEMENT		
<p style="text-align: center;">Agents, Loss Adjusters and Policyholders</p> <p>The following statements are made in accordance with the Privacy Act of 1974 (5 U.S.C. 552a): The Risk Management Agency (RMA) is authorized by the Federal Crop Insurance Act (7 U.S.C. 1501-1524) or other Acts, and the regulations promulgated thereunder, to solicit the information requested on documents established by RMA or by approved insurance providers (AIPs) that have been approved by the Federal Crop Insurance Corporation (FCIC) to deliver Federal crop insurance. The information is necessary for AIPs and RMA to operate the Federal crop insurance program, determine program eligibility, conduct statistical analysis, and ensure program integrity. Information provided herein may be furnished to other Federal, State, or local agencies, as required or permitted by law, law enforcement agencies, courts or adjudicative bodies, foreign agencies, magistrate, administrative tribunal, AIPs contractors and cooperators, Comprehensive Information Management System (CIMS), congressional offices, or entities under contract with RMA. For insurance agents, certain information may also be disclosed to the public to assist interested individuals in locating agents in a particular area. Disclosure of the information requested is voluntary. However, failure to correctly report the requested information may result in the rejection of this document by the AIP or RMA in accordance with the Standard Reinsurance Agreement between the AIP and FCIC, Federal regulations, or RMA-approved procedures and the denial of program eligibility or benefits derived there from. Also, failure to provide true and correct information may result in civil suit or criminal prosecution and the assessment of penalties or pursuit of other remedies.</p>		
the true and lawful attorney, for and in the name, place and stead of the undersigned in connection with Insurance Policy and/or Policy Number. The undersigned gives and grants unto said attorney full authority and power to do and perform actions as initialed below fully ratifying and confirming all that said attorney shall lawfully do or cause to be done by virtue hereof: _____ 1. Making application for insurance. _____ 2. Making crop acreage reports. _____ 3. Giving notice of damage or loss. _____ 4. Making claim for indemnity. _____ 5. Making policy change. _____ 6. Making transfers and cancellations. _____ 7. Providing program required production reports. _____ 8. Taking all actions related to the insurance coverage provided under the above identified policy and/or policy number.		ACKNOWLEDGMENT (For use by Notary Public) State of _____ County of _____
This Power of Attorney is signed and dated at _____ (City), (State) this _____ day of _____, _____ (Month) (Year).		<p>This Power of Attorney shall be filed at the office where the official insurance file folder is maintained and shall remain in full force and effect until written notice of its revocation has been received by the office maintaining the official insurance file folder (such revocation shall be placed in the official insurance file folder).</p>
PRINT WITNESS NAME		
WITNESS SIGNATURE	DATE	
PRINT INSURED NAME		
PRINT APPOINTEE NAME		(Use acknowledgment if required by the State where acknowledgment is taken) Signatures of the insured and the appointee must be notarized when required by law. Witness signatures are not required if notarized.
INSURED'S SIGNATURE	DATE	
APPOINTEE'S SIGNATURE		DATE